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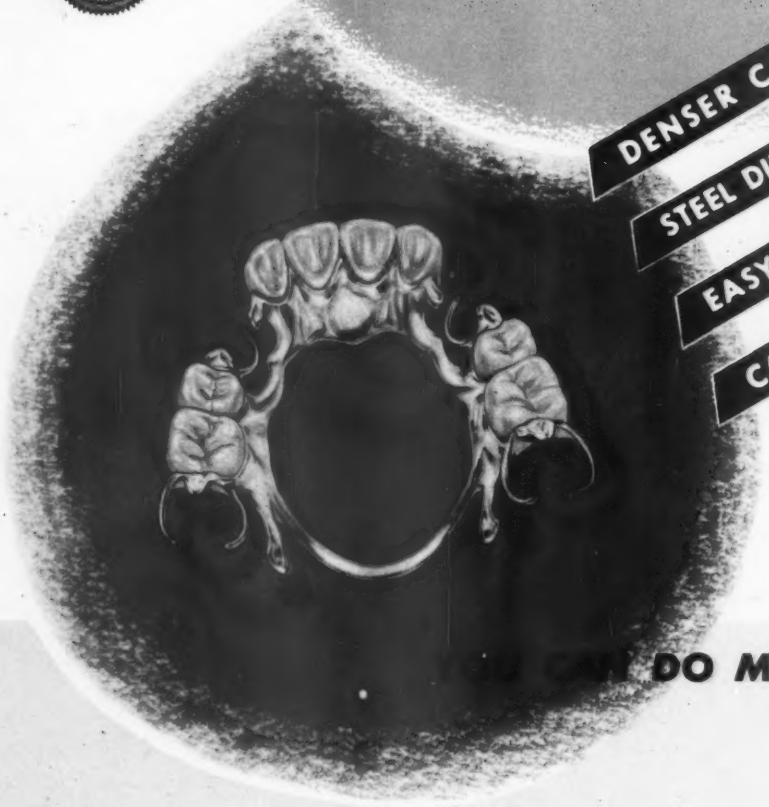

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CONSTRUCTIVE SUGGESTIONS--RESPECTFULLY SUBMITTED

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On October 16, 17 and 18, the House of Delegates of the American Dental Association will meet in Chicago. For all we know, this may be the last war time meeting. By the time the next national meeting is held, post war problems may be demanding the urgent attention of the delegates.

What these post war problems will be we rather well know. In the main, they are the problems with which Councils of Dental Health, national, state and local, are wrestling.

BUT the Committees of these Councils of Dental Health are composed of dentists. These dentists, like other dentists, are today very busy in their offices. Some of them, despite good intentions, are unable to give the problems the necessary attention. They do not know, for instance, where or how to gather pertinent information. If they succeed in getting the information, they are unable to analyze and evaluate it. If they reach a decision based on evaluation, they are unable to follow through their recommendations with programs of action. To make matters worse, many of these dentists serve on several committees whose problems, although indirectly related, are for purposes of study definitely separate.

These men need help. In order to work effectively, they must be provided complete and unbiased information on which to base their decisions. Studies should be made of public attitudes by trained, paid investigators. Included in such studies should be the attitudes of labor and industrial leaders, legislators, educators, members of other health professions and the man in the street. On the basis of the information gathered, it may then be necessary to institute programs for improving attitudes of particular groups. Also to be studied is the relationship of dentistry to the larger problem of public health, the place of health programs in a system of social security, and the extent to which an expanded program of social security can minimize those economic problems that breed religious and racial prejudices and hatreds.

Not only must this information be provided, means must also be developed that will encourage frequent interchange of ideas among the various Councils. Such an interchange of ideas will minimize duplication of effort in these busy days, possibly add wisdom to decisions or suggest unknown or unrecognized conditions.

Unless more assistance is made available to the Councils of Dental Health, it is not improbable that decisions will be made that are not wise or realistic. If mistakes are made, those affected will not appreciate the time that the Committees of the Councils of Dental Health are so unselfishly donating, nor will they excuse mistakes on the basis that those charged with responsibilities were too busy when their guidance was needed.

J. J. NEVIN.

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Opinions expressed in Tic editorials and articles are those of the writers and do not necessarily represent the opinions of Ticonium and the Ticonium Laboratories. Information is presented to you that, we think, is pertinent.

"Some method must be devised for getting dental care to the 80 percent of the population that now do not go to the dentist at all."

"Most of the 80 percent are unable to pay for comprehensive, high-grade dentistry provided by the individual practitioners."

"The plan provides for competent diagnosis and charting of the needs of every mouth before any work is done."

PROPOSAL FOR THE ESTABLISHMENT OF AN EXPERIMENTAL GROUP PRACTISE-DENTAL CLINIC

by Charles L. Hyser, D.D.S.
New York City

"Less than $30.00 per mouth should cover the rehabilitation cost on the basis of 30,000 mouths."

"There are certain technical procedures that are within the capacity of trained dental mechanics, such as the carving and shaping that produces a perfect inlay."

"The proposed institution is on the non-profit principle. Funds as they accrue will be devoted to research or to other measures designed to expand the institution."

Purposes That Underlie The Present Proposal

(1) To establish a dental clinic based on an organization of the diagnostic and technical procedures of dentistry in a manner calculated to shorten operative time, lessen the cost of dental work, and greatly improve its quality.

(2) To create new standards of dental education by using the proposed clinic not only as a service institution but also in time as a new type of graduate school in dentistry.

(3) To build up a dental research organization in those phases of dentistry for which such an institution may be fitted.

It will be in order to consider in some detail: I, the service aspect; II, the educational aspect; and III, the research aspect of the proposed plan.

I. The service institution

It is proposed to establish in New York City a dental institute designed to take care of large numbers of patients in the lower income groups. The New York City "project" should be a pilot organization, which, in the course of 5 years' operation, could develop the policies and procedures for providing high-grade dental service at a minimum cost which would be applicable in similar institutions in many other cities and towns.

The proposed institution is on the non-profit principle; funds that accrue—as they expectably will—will be devoted to research or to other measures designed to expand the institution and to increase its serviceability.

Premises

(1) Some method must be devised for getting dental care to the 80 percent of the population that now do not go to dentists at all, either because they cannot pay for dental service or because they do not realize the importance of a healthy mouth to general health, employability, and enjoyment of life.

(2) Most of the 80 per cent referred to above are unable to pay for comprehensive high-grade dentistry provided by individual practitioners.

(3) The mechanical part of dentistry—a very large part of it—can be so organized, in a group practice, that large numbers of patients can be taken care of more efficiently and at very much lower costs than are possible under the present system.

(4) No compromise in the quality of the dental service is involved.

On the contrary, the work should be better than average individual dental work anywhere for two reasons: **first**, the dentists would become progressively more expert under the intensive training and practice in the institute (with a rotation of operators in different mechanical procedures); and, **secondly**, the plan provides for the highest type of dental and medical supervision.

Moreover, the plan provides for a competent diagnosis and charting of the needs of every mouth before any work whatever is done. This means that the work done on every mouth is not patchwork to take care of dental emergencies but a thoroughgoing rehabilitation which will minimize the dental care needed during the rest of the patient's life.

Argument

Since the validity of this plan rests upon a radically changed method of organizing the mechanical procedures of dentistry, it is in order to demonstrate the practicability of group practice organization and the soundness of the theory that it is possible to take care of large numbers of patients in a short time by having a large number of dentists work under the supervision of a dentist of the highest competence and experience. The underlying theory is that the safest way to make a real science of dentistry is to distinguish between its mechanical and its scientific or medical aspects.

There can be no question that every mouth that needs dental care at all needs the diagnostic and supervisory skill of a first class all-round dentist. Most of the actual work in the mouth, however, does not require the detailed care of this broadly trained, all-round dentist and, indeed, the faculties of such a dentist are wasted in being thus applied. Just as it is now recognized that the busy dentist cannot wisely undertake to do his own laboratory work, so it is in order to recognize that neither should he carry out in detail all the mechanical procedures involved. Many of these can better be taken care of with the assistance of technical operatory and should be—for the good of the patient.

There are certain technical procedures that are within the capacity of trained dental mechanics such as, the carving and shaping that produces a perfect inlay. In preparing cavities for inlays, the individual practitioner consumes a good deal of time, a not inconsiderable part of which goes into changing instruments and making various preparations for taking impressions and bite. Organization of these stages by allotting purely mechanical processes to competent technicians (dentists, of course, but not necessarily competent in the full scientific and medical implications of dentistry) would definitely shorten the time involved in the whole procedure.

It is true that there are certain cases to which the system would not be adaptable,

for instance, preparation of deep and complicated cavities, root canal work, and periodontic treatment. These require individual and unified treatment which would have to be separately provided for and carried out in separate departments of the dental institute.

Essential in this set-up is a consulting staff or diagnostic board composed of fundamentally trained dentists competent in every diagnostic procedure and capable of planning the work on the mouth as a whole for every patient. Under the guidance of a member or members of this board every patient's mouth would be accurately charted and instructions prepared for every dentist. This board also, or part of it, would pass upon the finished work with reference to every patient.

Cases having obvious systemic relationships would be referred to a competent physician retained as a member of the staff.

When the consultative work has been done, the diagnosis comprehensively made and work planned for the given patient on the basis of the whole mouth, operation passes to a "battery" of dentists trained for each type of treatment needed.

In the operative work for inlays, a 10 chair arrangement might consist of 5 to be used by men doing nothing but preparing cavities, 2 to be used by men doing nothing but taking impressions, 3 to be used by men doing nothing but fitting the inlays. If the group preparing the cavities turned out 4 each per hour, the rest of the group could take the impressions and fit them; this group of 10 could easily finish 20 inlays per hour, or 160 per day. Inlays by the indirect method should be used whenever possible because more patients can be treated and the technicians do most of the work in the laboratories.

In the prosthetic work, a similar group of 8 might consist of 2 taking impressions (with the new colloid impression material it is easily possible to take 5 impressions for bridges or partial dentures per hour, if everything is ready and the inlays are fitted and completed); 2 taking bites and choosing the colors; and 4 fitting the bridges and dentures. This prosthetic group would be capable of finishing 10 partial dentures or bridges per hour or 80 in an 8-hour day.

In the synthetic filling work, a group of 10 might include 4 to prepare cavities, 4 to fill them and 2 to polish. It is assumed that each operator drilling could easily prepare 6 per hour, which the others could finish. This set-up would apply to amalgam fillings as well.

Add 2 surgeons, 2 radiologists, 8 hygienists, and 2 supervising dentists. This group of 42 operators working at full capacity, could turn out daily about 200 synthetic fillings, 160 inlays, and 80 dentures and bridges. These figures are subject to revision as plan develops.

A completely equipped, well-manned laboratory of so-called technicians would do the casting and finishing of the cases exactly as the commercial laboratories do at present for practically all dentists. This laboratory would be an integral part of the clinic.

The foregoing illustrations must be considered as tentative and flexible figures. In actual operation it may be found that time would be wasted by too much fractionation if so, that can readily be changed. The men working in those positions would complete training in one department and then move on to the next e.g. from operative to prosthetic. While working in the inlay department an operator would be changed frequently from cavity preparation to impression taking or inlay fitting and finishing. This would apply in each department to relieve monotony. The patient would of course be anesthetized before the work is started or if that is not feasible gas anesthesia shall be given at the chair to save time in operating.

Estimates of Cost

While exact figures cannot be wisely given in advance of actual experimentation, it is possible to make a financial forecast that is based upon reasonable assumptions.

The first of these assumptions is that the dental needs of the adult poor, in whose interest this dental institute would first be established, may be regarded as worse than the dental needs of the average citizen in the total population. According to the Journal of the American Medical Association of October 4, 1941, the man rejected for dental defect at that time (who may be reasonably regarded as representative of adult civilians of the lower economic group to the interest of which this proposal is first addressed) has an average of 22 permanent teeth attacked by caries, 13 that had already been extracted, 2 that needed to be extracted, 2 that had been filled, and 5 that were carious and justified treatment by filling. It follows as a reasonable assumption that such a mouth would need 5 inlays, 2 fillings, a prophylaxis, X-rays and 2 dentures.

The battery of 42 men described above would accomplish the following:

		Per Patient	Patients Completed Per Year
Inlays	48,000	5	9,600
Bridges	38,400	2	17,200
Fillings	60,000	5	12,000

But for the maximum economy the clinic should handle at least 100 patients per day or 30,000 per year. To make this possible, the arrangement would need to be balanced as follows:

Number of Operators		Per Day	Per Year	Patients Completed
Inlay	(32)	510	155,000	31,000
Bridge	(15)	208	62,400	31,200
Filling	(25)	500	150,000	30,000

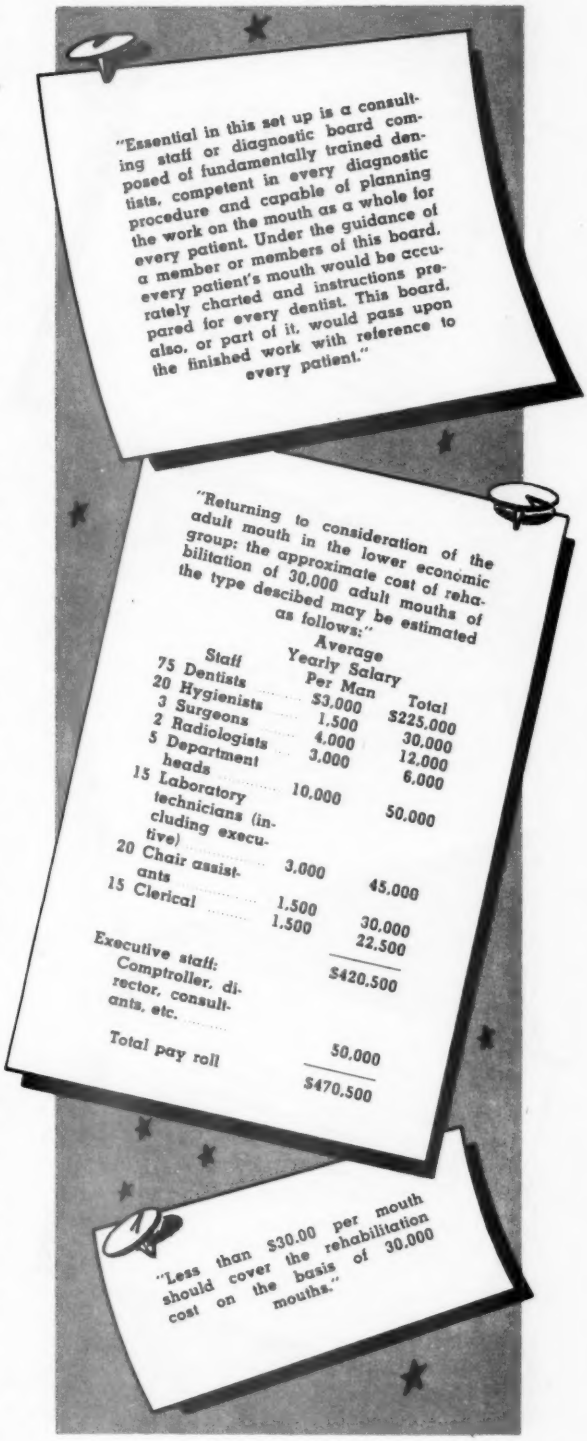
Thus to finish 30,000 adult mouths in a condition similar to that of the rejected draftee's cited above would require 70 operators working 300 days per year, probably about 20 hygienists, 6 surgeons, a staff of chair assistants, clerks, and laboratory technicians. Also, to provide for emergency, about 5 extra dentists should be employed to fill in in order to keep the arrangement moving smoothly.

The cost of dental work on children must be estimated according to entirely different principles. The work for children would be simpler, it would be different, it would be less expensive. An entirely different table of procedures and costs must be drawn to cover the children's work—plans for which I shall be glad to submit.

The system proposed is notably applicable to the difficult field of orthodontia. It would follow that malocclusion, now so frequently not dealt with at all or attempted at too late a stage, would be within the reach of practically everyone. A case that under the present system ordinarily costs from $500 to $2000, could be corrected, in the institute, for from $50 to $100.

Returning to consideration of the adult mouth in the lower economic group: the approximate cost of rehabilitating 30,000 adult mouths of the type described above may be estimated as follows:

Staff	Average Yearly Salary Per Man	Total
75 Dentists	$3,000	$225,000
20 Hygienists	1,500	30,000
3 Surgeons	4,000	12,000
2 Radiologists	3,000	6,000
5 Department heads	10,000	50,000
15 Laboratory technicians (including executive)	3,000	45,000
20 Chair assistants	1,500	30,000
15 Clerical	1,500	22,500
		$420,500
Executive staff: Comptroller, director, consultants, etc.		50,000
Total pay roll		$470,500


"Essential in this set up is a consulting staff or diagnostic board composed of fundamentally trained dentists, competent in every diagnostic procedure and capable of planning the work on the mouth as a whole for every patient. Under the guidance of a member or members of this board, every patient's mouth would be accurately charted and instructions prepared for every dentist. This board, also, or part of it, would pass upon the finished work with reference to every patient."
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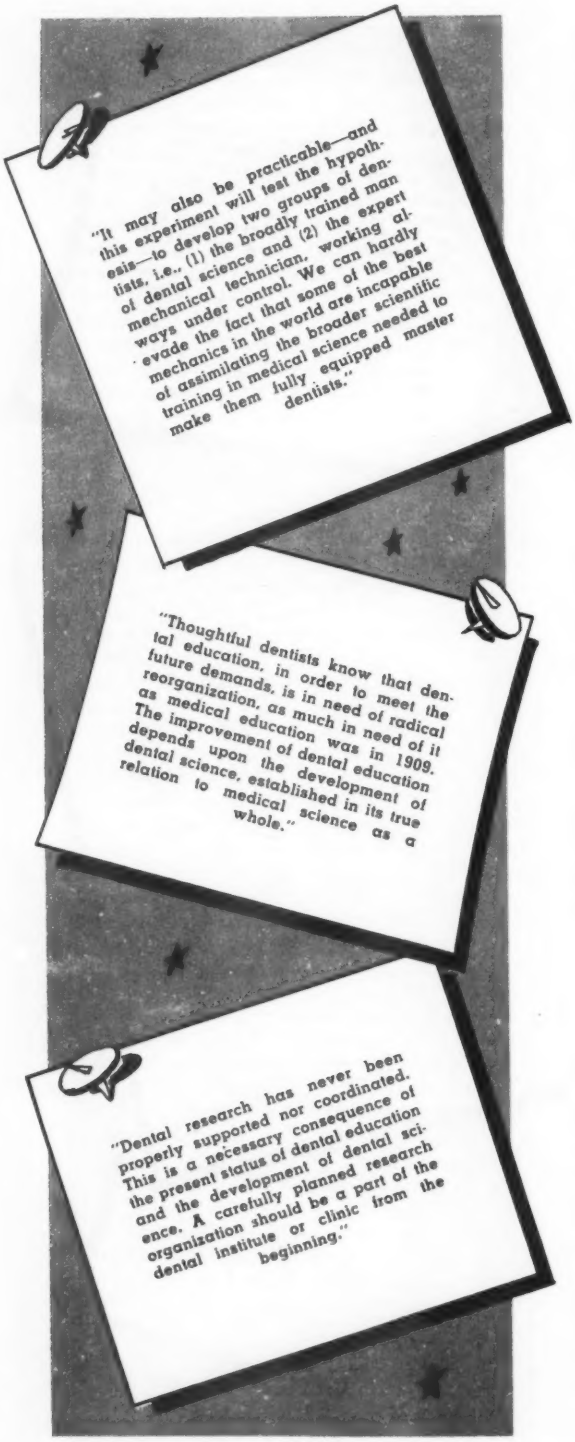
Staff
Average Yearly Salary Per Man
Total
75 Dentists $3,000 $225,000
20 Hygienists 1,500 30,000
3 Surgeons 4,000 12,000
2 Radiologists 3,000 6,000
5 Department heads 10,000 50,000
15 Laboratory technicians (including executive) 3,000 45,000
20 Chair assistants 1,500 30,000
15 Clerical 1,500 22,500
$420,500
Executive staff: Comptroller, director, consultants, etc. 50,000
Total pay roll $470,500
"Less than $30.00 per mouth should cover the rehabilitation cost on the basis of 30,000 mouths."


"It may also be practicable—and this experiment will test the hypothesis—to develop two groups of dentists, i.e., (1) the broadly trained man of dental science and (2) the expert mechanical technician, working always under control. We can hardly evade the fact that some of the best mechanics in the world are incapable of assimilating the broader scientific training in medical science needed to make them fully equipped master dentists."
"Thoughtful dentists know that dental education, in order to meet the future demands, is in need of radical reorganization, as much in need of it as medical education was in 1909. The improvement of dental education depends upon the development of dental science, established in its true relation to medical science as a whole."
"Dental research has never been properly supported nor coordinated. This is a necessary consequence of the present status of dental education and the development of dental science. A carefully planned research organization should be a part of the dental institute or clinic from the beginning."

In the average adult mouth in the group to which this proposal is addressed, at least three-quarters of the bridges would be bars, lingual or palatal. In stainless steel these would cost 50 cents each; in gold, about $1.90. The gold in the inlays would average about $1.50.

Cost of materials can only be suggested:

Supplies: Estimated about $800 per operator per year	$60,000
Cost of precious metals, stainless steel, teeth, acrylic, etc.	250,000
Payroll	470,000
Total	$780,000

Cost per patient:

Less than $30 per mouth should cover the rehabilitation costs, on the basis of 30,000 mouths.

In this consideration of costs, it is important to remember that the figures are referred to mouths comparable to those of the 20.9 per cent draftees rejected for dental defect. The remaining 79.1 per cent, or four-fifths of the draftees (or of the adult population generally), would have mouths that could be rehabilitated more easily and more cheaply.

The original investment in premises and equipment cannot be reasonably figured. The dental equipment, chairs, engines, lights and instruments should be about $150,000, but the building or space for the clinic will depend entirely on the money available and the desires of the board of directors. An adequately equipped building needs to be neither elaborate nor expensive; to make it either of these things would be both bad business and bad psychology.

II. Relation of the Proposal to Dental Education

Thoughtful dentists know that dental education in order to meet the future demand is in need of radical reorganization—as much in need of it as medical education was in 1909. The improvement of dental education depends upon the development of dental science established in its true relation to medical science as a whole.

The proposed institution cannot fail to establish the highest standards for dental diagnosis and for every type and grade of dental operative work. The establishment of these standards cannot fail to influence the organization of teaching in the present dental schools. It is not hard to foresee the time when every first-grade dental student will expect to serve an internship and clinics of this type. The type of

work done in the clinic will establish standards which the public will understand and appreciate. The whole course of dental education, moreover, will be influenced by the clinic's research activity outlined below. The men that go out from this dental institute, will create a community of dental scholars who will profoundly influence dental education in the future. By evolutionary process, dentistry, under the influence of such clinics and research centers, must become a field as dignified and as fascinating as any other branch of medicine.

Students of this plan may here raise the question as to whether the emphasis on expert mechanics in the staff of the dental institute will not tend to emphasize the mechanical rather than the scientific nature of dentistry as a whole. It is quite true that the dental operators on the staff of the institute, working under the supervision of broadly trained dentists are being paid for expert mechanics rather than for dental wisdom generally. At the same time they are doing this mechanical dental work in the institute at a reasonable salary, however, they have available the resources for postgraduate work and for research. For these activities they are not paid; their salary is for their expert mechanical contribution, but they are daily surrounded by all the opportunities for profound training in the broader aspects of dental science. They are not doomed to be mechanics forever and may properly look forward to advancement.

It also may be practicable--and this experiment will test the hypothesis—to develop two groups of dentists, i.e., (1) the broadly trained man of dental science and (2) the expert mechanical technician, working always under control. We can hardly evade the fact that some of the best mechanics in the world are incapable of assimilating the broader scientific training in medical science needed to make them fully equipped master dentists.

III. Relation of the Proposal to Dental Research

Dental research has never been properly supported nor coordinated. This is a necessary consequence of the present status of dental education and the development of dental science.

A carefully planned research organization should be a part of the dental institute or clinic from the beginning. The clinic, which should be closely associated with a large hospital or university, offers basic facilities for a much needed research center in dentistry. The research facilities involved in the clinic include:

(1) Unusually large numbers of patients,

(2) All kinds of mouths and all grades of dental needs;

(3) A diagnostic group of medical and dental men, leaders in their respective fields; and

(4) Competent laboratories.

What the dental clinic does not include are the basic science laboratories that are to be found only in a great university. Clearly dental research work needs to be carried on with all the resources of chemical and physical laboratories and all available counsel from university departments of anatomy, physiology, medicine, pediatrics, genetics, and anthropology. The institute's planning board for research should include outstanding figures in all of these divisions and departments.

It seems essential, therefore, that, on the research side, the dental clinic, should be, from the beginning, associated with the hospitals, laboratories and departments of a great university and that the research program should be worked out cooperatively between those in charge of the clinic and a university. In the course of time, the service unit and others that may be established should become the clinical center for research in all first-grade universities that have a conception of the importance of dental science.

It is really the research organization associated with this clinical unit that will create that preventative dentistry which has so long been an obviously needed contribution to the standards of public health.

Outstanding in the research aspect of the dental institute is the fact that the cost of research is carried along as an integral part of the finances of the institute and is not dependent on research grants from outside sources. This means that the research is permanent, continuous, and progressively expanding, an essential and fundamental part of the service and educational functions. The cost of the research is a fixed part of the service fee.

The present proposal, therefore, seems to offer not only a scientific and economic approach to the thus far insoluble problem of getting high-grade dentistry to the public at reasonable cost but also to the problem of preventive dentistry and its undeniable relation to general health, to productivity, employability, and capacity for enjoying life.

5 East 57th Street
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OFF THE

by S. Joseph Bregstein, D.D.S.
Brooklyn, New York

Have you ever been put on the spot by the query "But, doctor, John is only 16 and I've had his teeth attended to ever since he was a child. How is it that he has so many cavities now? Are his teeth chalky?"

You visualize the aged Hippocrates leaning on a long staff topped with the emblem of caduceus. From his heavenly abode, he looks down upon you suggesting that with one false move, your halo shall be stripped from you.

So, in conformity with the dental code of ethics you omit the eyebrow shrugs, or the faint praise, and, you protect all preceding fellow practitioners by saying, "Perhaps John's been eating too much candy, or maybe, he lacks vitamins."

Off the record, let's close the doors and talk over just between us what has really happened to John's teeth. At the age of five, John's mama took him to Dr. A., a lovely fellow with the cute little dark moustache. At that time she was told that Johnny had some cavities and they were quite deep. He had tested them all with an explorer. But, he felt that the eruption of the second teeth was not far off and unless the teeth gave trouble, she ought to leave them alone.

Meanwhile, the cute dentist put some zinc oxide and silver nitrate into the cavities and from then on kept his fingers crossed. He didn't radiograph the teeth even though his highly polished mahogany colored machine fairly cried to be used.

About four months after the zinc salve incident, Johnny woke up in the middle of the night with dots of pain and a swollen jaw. Papa couldn't sleep, got sore as hops and said, "Whynell didn't you take him to my dentist? I thought you said your doctor with the moustache finished Johnny's teeth. How come they hurt him now?"

Next morning Johnny and his swollen jaw were ensconced in the dental chair of Dr. B. He put on his pince-nez glasses, uttered a few a-hems and took a roentgenogram of the offending molar. With the fervor

of a pallbearer he announced that the tooth was abscessed and that it should be removed at once.

"You'd better take the tooth out today, then, Dr. B. Johnny's a good boy and he'll let you do it," said Mrs. J. with a tremulous voice. Dr. B. told her that whereas he was considered the best dentist East of the Mississippi and that he invented a technique for recording the mandibular paths, he did not, however, treat children, much as he loved the little people. He referred her to Dr. C. a good "gas" man. The tooth was extracted and for the balance of that year Johnny suffered no more dental pains than occasional sharp twinges. He had been getting many colds and his color resembled that of a cold storage chicken. Mother and dad took him in one day for a physical checkup to Dr. M.D. who suggested that there might be the etiologic factor of focal infection.

A friend of theirs "used" Dr. C. who did work on children and they visited him in due course. He radiographed the boy's teeth and discovered ten cavities and three more abscesses on the deciduous teeth. Upon hearing the fee for complete dental rehabilitation, the patient's mother exclaimed, "But, Dr. C., isn't that a lot of money for just filling a child's tooth? My last dentist charged about half. I think we will have to get another estimate."

So, Johnny, the innocent bystander, was marched into Dr. D's office who perfunctorily glanced over the mouth with mirror and explorer as he hummed a popular tune. He gave Johnny a lollypop, patted his head and said to his mother, "Not much to be done here, he's got a few cavities. We can fill them up with cement, that's good enough for the temporary teeth. It will cost you only a couple of dollars each."

"Whatever you say, Doctor D., I'm leaving him in your hands. I don't care how much it costs as long as his teeth are in good condition. We have had so much trouble with his teeth and it's so hard to find a good dentist, especially for children."

Sometime later, the patient is at the dentist's with his mother. "Dr. D., will you please give Johnny a note for school saying that his teeth are all right. You remember you fixed him up about a year ago. The school is always after him for a note."

"What, you say to have his teeth cleaned? Again? No, that takes off the enamel. I never had any trouble with my teeth until the dentist cleaned them and took the enamel off. And then when Johnny was born I lost

a back tooth. You know, Doctor, they say, 'A tooth for every child!' No, I didn't have it replaced, it's a **back** tooth, it doesn't show anyway."

Dr. D., with some reluctance, wrote out a note stating that Johnny's teeth were in good condition. Shortly thereafter, another of our young hero's teeth started fireworks while the Dr. D. was away on vacation. So this time they went to Dr. E. He removed two teeth and arranged to fill two permanent molars. The caries were deep seated and required anesthesia for excavation. But Dr. E. didn't believe in it because "you can't tell when you're near the pulp." So, Johnny squirmed and yelled at each visit while the dentist drilled away to his heart's content. John was an uncooperative patient according to him and therefore he couldn't remove all of the decay. So, he applied some silver nitrate and filled the teeth with a palm full of amalgam. John is now sixteen and he is visiting Dr. F. with his mother. Radiography has disclosed that there is caries beneath the fillings, interproximal decay, malocclusion and a few other conditions which undoubtedly could have been avoided. Now she asks, "Are his teeth chalky?"

These snapshots are but a few of the conditions prevailing in dentistry today. We find many dentists unscientific, lackadaisical, and perhaps uninterested in educating patients. What is the reason for this? Surely organized dentistry has provided courses in advanced dental techniques which are available to all of its constituents. They certainly must realize that radiography is the basis from which all diagnostic procedures have their origin. What, then, is the answer to the reasons why so many people are meandering about with poor dentistry in their mouths? "Poor dentistry" does not necessarily have reference to decay under fillings or anterior gold shell crowns. It implies in the main faulty diagnosis and injudicious application of restorations. For example, we recently examined the mouth of a young woman who had a restoration on the left side of the mandible. It was an artistically executed bridge—a large well balanced inlay on a first molar supporting a cast pontic second bicuspid. This was locked in a fixed movable junction on an inlayed first bicuspid. The craftsmanship of this bridge was entirely beyond criticism. In fact, it was a veritable work of art, mechanically. But, the restoration was valueless because it couldn't function, there were **no upper opposing teeth.** Furthermore, the molar abutment tooth was tilted mesially and there was evidence radiographically of periclasia. There were also teeth missing in both jaws on the right side. This bridge was inserted but a few months prior to this patient's presentation for examination. Surely, a dentist who was such a skilled craftsman ought to have thought about complete mouth rehabilitation. The patient was intelligent, dental conscious, and cooperative. Now, in order to accomplish complete oral reclamation, this finely made restoration has to be removed. Wonder what's on the patient's mind now? This is not just one of those isolated cases used to prove a point. It can be shown by many examples that the sins of omission by far outweigh the breaches of ethics through deeds or acts.

We are admonished quite regularly not to pass comment upon prior dental treatment because we do not know under what peculiar circumstances or exigencies it was performed. It is all well and good to be philosophic and say, "Forgive them, O Lord, they know not what they do."

But off the record, and just between us dentists, it is not a case of them not knowing what to do. It is rather a case of lack of fortitude and conviction in saying to **every** patient, "I know what you ought to have done. This is based upon modern accepted principles of fine dentistry. This is the way I shall rehabilitate your oral cavity. Any other way, even though you may request it (and say now that you would accept responsibility) would be contrary to your interests and against the ethical precepts of my venerable profession!"

This is not just another one of those excursions into the realm of Utopian fantasy. It is a reality, it is an actuality which is within the capabilities of every able-bodied dentist. It is as practical a procedure as our daily ablutions.

Starting this moment, if every dentist everywhere were to have the courage of his convictions and tell the truth, the whole truth and nothing but the truth, patients' attitudes toward dentistry would be revolutionized overnight. And this goes for physician's reactions, too!

Every patient should be completely radiographed and study models made from impressions of the mouth. The case should be carefully studied, additional tests made and the procedures planned. The dentist must visualize in advance what he intends to accomplish and just what shall be completed at each visit. He will then know what time

shall be consumed, what his costs are to be, what contingencies may arise, and what fee is commensurate with the exactitudes or specialties of the services. Then he is ready to discuss the case with the patient and a consultant from home.

All of this is not intended as a hocus-pocus magic formula which would make our present plight vanish into thin air.

There are a number of other factors or shall we say allegorically, a few other actors in our play.

For many years, there has been a watchword in dentistry which we have been using indiscriminately. It is the hackneyed phrase, "Preventive Dentistry."

Thirty-six years ago, Dr. Victor C. Bell wrote a book, "Popular Essays upon the care of the Teeth and Mouth." In the first chapter, he listed certain fallacies which existed in the minds of people at the beginning of the Twentieth Century. Here are a few:

"Doctor, does not the cleaning of the teeth by dental instruments ruin them?"

"Is not the food tasteless to the wearer of artificial teeth?"

"In filling the teeth are not their nerves killed, and their vitality thus destroyed?"

People today are still asking the same question. Is it not time then that we should urge some attention toward altering that time-worn phrase "Preventive Dentistry?" Just what are we telling Mr. & Mrs. John Q. Public to prevent? Can they, or in fact, can we actually prevent caries or pyorrhea? We perhaps can alleviate this twin scourge or at times lessen its incidence, but, when it comes to actually preventing it, you and I know that at this writing that's a factor represented algebraically by the letter "X" the unknown.

Why then, tell people to prevent something which as yet cannot be prevented? Ought we not direct our attention then toward an examination of our basic premises? To teach something, there must first exist certain facts which we want to impart. Then, there has to be a method or technique used to educate the recipients of that information.

For more than a quarter of a century we have told the public "Brush your teeth— see your dentist." People now want to know WHY? Tell them! Don't talk about preventive dentistry unless there is something that can be prevented. We all know patients who for many years have diligently and faithfully received adequate dental care. If the implication embodied in the phrase Preventive Dentistry were true then in short order these patients ought to expect that they would be free from further caries and periclasia. But, off the record, you and I know that such is not the case. In spite of "preventive" measures they return regularly for more drilling and for more gum treatments.

Isn't it about time, then, that we changed our slogan and began to teach the public the "facts of life" as we know them? We do know this, that the nearest approach to a constancy in oral health can be accomplished through complete mouth rehabilitation along functional concepts and that this can be maintained by regular period adjustments.

If we are going to teach the public what we know to be true facts, let us enlist the cooperation of pedagogues whose business it is to devise methods of teaching. It is as presumptuous for dentists to promulgate an oral hygiene teaching program in the schools as it would be for teachers to come into dental meetings and tell us techniques of dental operation.

Here are a few thoughts which might be of assistance for the post-war renaissance of dentistry.

1. Organized and extended programs in elementary and secondary schools based upon modern pedagogical techniques and not on methods devised by dentists.
2. Make the public dental conscious by enlisting the aid of life insurance companies. No policy of any amount ought to be issued without a clean slate of oral health from a competent dentist's report including radiographic diagnosis.
3. Make it a requirement that all food handlers submit a clean bill of dental health every six months.
4. Incorporate dental education as part of the advertising program of commerical oral products on the radio. Radio announcer could say, "An authority states that pyorrhea is caused by .....
(two or three paragraphs of authoritative dental educational material). Listen in tomorrow for more information on "How Your Pyorrhea May be Cured."
5. Build educational text on the premise of complete mouth rehabilitation. This is the only truly honest prevention. We have graduated from the "Brush Your Teeth—See Your Dentist" era. People now want to know WHY? Tell them!

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THE ROLE OF DENTISTRY IN CITIZENSHIP

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The third paragraph of the pledge taken by members of the American College of Dentists reads as follows, "I pledge Myself, as a member of the American College of Dentists, to uphold to the best of my ability the honor and dignity of the dental profession, and to meet my ethical obligations to my patients, to my fellow practitioners, and to society at large."

Dentistry has certainly done well by its patients and most assuredly developed a fine esprit de corps. But one may question whether it has fulfilled its obligations to society at large. Brigadier General Mills has reported that the Army Dental Corps has rendered dental service to 5,000,000 men who had never been treated in civilian life. And the fact still remains that 3 out of 4 people in this country did not visit the dentist before the war. Dentists are busier today than ever before and one may rightfully ask whether the increased demand for dental service is due to the fatter paycheck of the average worker or to the decreased dental personnel which must not only satisfy the needs of its own patients but also those of the dentists who are now in the armed forces.

If dentists are agreed that dental care is a necessary and vital part of health care then the profession must see to it that those who have thin or empty pocketbooks are not deprived of dentistry. If dentists are agreed that finances prevent the average American from buying health dentistry then the profession is duty bound to devise ways and means of making it available. If dentists feel that the manner of payment is not their concern, they must not oppose methods developed by the public.

A good citizen is not he who abides by the laws of his community solely; or in times of emergency and war buys bonds and gives a little of his time and money to primary patriotic endeavors so that he can in clear conscience concentrate the rest of his energies upon his own business. Good citizenship is an all-time job and its first law is the advancement of public welfare.

Dentistry has perfected its technics, its operative skills, its instrumentarium, its prosthetic concepts; it has evolved from a hand-maiden to the physician to the status of an independent profession; it has developed first-class schools, a strong organization and a good journalism. But all these things it has done

essentially for its own sake: it has built its nest and feathered it.

It is time that dentistry and all the health professions lifted their sights and commenced to think in terms of the new day that is dawning all over the world. The blood and tears and sweat and treasure are the bricks and mortar of an expanding civilization whose cornerstone is freedom from fear and want.

It is preposterous to assume that in this rapidly changing situation capital, labor, government and industry will be deeply affected and altered in their functions and purposes but that medicine and dentistry will be left untouched.

What organized dentistry needs today are not spell-binders and stand-patters but intelligent men with enlightened social policies. The American way of life once accepted slavery, the kerosene stove, the horse and buggy; private business at one time or another controlled education, the roads, the mails, all the public utilities; private enterprise reigned supreme over commodities like foods, drugs and clothing, there was no floor on hours of labor or wages, no collective bargaining, no Federal Trade Commission, no T.V.A. or S.E.C. With each change the American way of life became different to the common benefit of the whole nation.

Those who speak so glibly of regimentation fail to remember that as our society becomes more and more complex government must intervene to protect the rights and freedoms of the citizen from avid activities of private and vested interests.

Medicine and dentistry today are private interests in the true sense of that term and as a matter of self-protection they should seriously consider the inerasible handwriting on the wall.

Tolerance, human sympathy and practical wisdom properly mixed and applied may still preserve the integrity of the health professions from our American electorate which is daily growing more cynical of our attitudes and methods. Unless we admit that the larger welfare and the higher good of the people of this country takes precedence over our own, we run the risk of legislative extension of health services without our participation in their planning. We can bury our heads in the sands like ostrich and refuse to heed the signs of the times, we can observe the tendencies and do nothing or we can enlist in the movement for wider distribution of all health services and from within its ranks guide and lead it to the common advantage of all concerned.

"Peace will be almost meaningless without betterment of daily existence," said Bernard Baruch in accepting the Churchman award for 1944.

This writer believes in "practical idealism." He believes that all people, everywhere are entitled to food, clothing, shelter and health care. These are the basic essentials of tolerable living. Society in Europe, Australia, New Zealand and this country for the past five decades has tended to make the lot of the average family more stable through social security. Health and its counterpart, sickness, are cumulative. Except for the wealthy, sickness may break the economic back of any American home.

The Murray-Wagner-Dingell Bill (S.1161) has been proposed, said Senator Wagner, "to provide a continuous income to American families when wages stop because of old age, unemployment, sickness, or premature death." . . . . it aims "to spread the risks and equalize the burdens so that no American family in this rich land need be without the minimum income required for subsistence." It uses the device of insurance to attain its objectives.

Dentistry, except for a provision for a two year study is not mentioned in the Bill. The omission is a tacit admission of the ineffectiveness of the education of the public to the value and need of dental health service. There is further the possibility that when a national health care measure is finally passed without the inclusion of dentistry, the dental profession will discover that medicine has taken over some of its functions and that to gain entrance into the social security system it may be compelled to surrender its present independence and become subservient to medicine in its ministrations. It is simple protective common sense, therefore, that dentistry insist that in all proposed health legislation, dentistry and medicine be placed on equal footing.

In 1938 the American Association for Social Security publicized a Model Health Bill. It provided specifically for "dental service for relief of pain through surgical intervention" and empowered the Social Security Board, "subject to such limitations and conditions as it may prescribe" to provide any or part of the following benefits: "special surgical and dental appliances, the services of a general dental practitioner or a dental specialist." The Association still supports these proposals.

In 1939 the Committee on Social Welfare of the City Club of New York issued its report on Health Insurance. Discussing "Dental Care" it said, "It is an acknowledged fact that the absence of dental care may lead to dis-

abling disease. Yet only about 21% of the population receive any dental care during the year. In the case of school children one survey showed that 94% needed such care. We realize that inclusion of dental care in an insurance plan must of necessity increase the cost but we nevertheless believe that it is an essential for which provision should be made. It is an appalling human fact that in the United States today, where dentistry has reached a scientific excellence unequalled in the world, an enormous proportion of the population has never visited the dentist." It recommended a 5 point health insurance plan to make possible a budgeting or prepayment for illness. Point I "would afford medical care for all sickness other than chronic illness and illness cared for by government agencies, including as basic essentials, preventive measures, hospitalization, services of specialists, maternity and dental care."

The National Committee on Social Legislation of the National Lawyer's Guild calls the Wagner Bill "a new social security charter for America" and finds that "dental and nursing care are an indispensable part of adequate medical care. . . . We believe that the Bill should provide dental and nursing care at least equal to the Canadian proposals."

The Health Council of the American Labor Party and Trade Unions in order to protect the practice of dentistry and to write into the body of the Bill minimum basic dental services suggested the following two recommendations as amendments to the Bill:

Recommendation One

Dentistry and dental service. "Dentistry" and "dental services" should apply only to services rendered by practitioners of dentistry who are duly accredited and licensed graduates of dentistry; and the term "appliance" shall not be interpreted to apply to dental prosthetic, operative or orthodontic restorations.

Recommendation Two

Minimum dental health services. A minimum of basic dental health services by the dentist should be included with "medical" and "hospitals" benefits. The following dental services should be included as part of "health benefits," from the very start of the establishment of health insurance:

1. **Full mouth examination** (History, x-rays, study models, diagnostic aids)
2. **Prophylaxis** (At least one annual treatment)
3. **Fillings** (Plastic and alloys)
4. **Removal of teeth** (Extraction to eliminate infection and eradicate disease)
5. **Mouth replacements** (Essential for employment)

In April 1944 TIC (page 5) I pointed out that "basic dental services in a labor health security program must have three objectives. 1) Elimination of pain, 2) elimination of infection and disease of dental origin and 3) restoration and maintenance of the mouth or oral cavity in a state of good oral hygiene or health."

Last year the American College of Dentists published "Dental Care for Adults" by Dorothy Fahs Beck. This was a study of 485 adults who received essential and sustained dental service over a 4-5 year period at the Dental Health Service, a low-fee pay clinic in New York City. Miss Beck found that the major source of expense in dentistry arose from neglect of primary lesions. Time and money could have been saved "if early and preventive services had been obtained." Initial care expense far outdistanced maintenance care costs. With the medical invalid costs continue. Says the report, "Adequate dentistry during the high caries incidence period of childhood is the keystone of dental health throughout the adult years. For this reason adequate dental care for children is the foundation for all constructive and forward-looking public dental care programs." The largest item of the initial costs to patients was artificial replacements. Total initial costs amounted to $52.66 per patient; maintenance costs however added up to $10.05. One can readily see that early dental care continued over a period of time would radically reduce the costs of the over-all dental bill.

The Allied Dental Council which recently merged with the First and Second District Dental Societies of the Dental Society of New York also recommended the immediate inclusion of dental care in the Wagner-Murray-Dingell Bill. Its National Dental Health Planning Committee made the following recommendations for a dental program:

1. **Dental benefits:** These shall consist of prophylactic, diagnostic, surgical, operative and therapeutic treatment.
   Dental prosthesis for health and employability shall be included.
   A children's dental program shall be provided for and it shall receive priority.
2. **Educational facilities** shall be increased to provide for the training of sufficient dental personnel to supply these services.
3. **Services of dental specialists** shall be provided for on the same basis as the services of medical specialists.

4. **Dental facilities** shall be established in the various communities in accordance with local needs.
5. **The name of the National Advisory Medical and Hospital Council** shall be changed to the National Advisory Health Council.
   Dentistry shall be represented in this Council.
6. **Specific financial provisions** for the effective execution of this program shall be made.

The Committee recommends that these additions be submitted to Senator Wagner, Senator Murray and Representative Dingell for inclusion in the Bill (S-1161, HR-2861).

It will be observed that a number of serious minded groups have the vision and imagination to include dentistry in a health care program **now.** For a program of health service without dentistry will function much like a lame horse—it will get along but surely not as efficiently as might be hoped. What has been noted here regarding dentistry applies with equal force to all the other services which together constitute a complete coordinated health service system: optometry, podiatry, nursing, pharmacy, etc. . . .

In the Journal of the Michigan Dental Society, May 1942, Marcus L. Ward warned that if dentistry and medicine do nothing about the health of the people, the government will be obliged to do so through social security legislation.

In September 1942 J.A.D.A. Dean Houghton Holliday of Columbia stated that if public health service were broken down into separate efficient units, obstetrics would be one, internal medicine would be second and dentistry would be a third.

The American people and Labor particularly are gravely concerned in the axiomatic privilege of "life, liberty and pursuit of happiness." They are increasingly demanding for themselves and their children that the human and material resources of the country be organized to service human needs. There are 60 million men and women in the armed forces throughout the world, over 12 million of them in this nation. There have been tremendous shifts in population, in the character of the labor force, in types of employment, in standards of living, in methods of production.

There is no road back to the pre-war set-up of living and doing. Outlining a nine point program of post-war objectives at an I Am An American Day ceremony at the New York City Central Park Mall on May 21, 1944, Senator Robert F. Wagner said, "We must enlarge the scope of social security so as to make available to rich and poor alike the benefits of modern science, not only in the cure of disease, but in the promotion of a higher standard of health among the entire population."

A higher standard of health is one of the prizes for which the average American is fighting today.

Dentistry has still an open opportunity to assist cooperatively in planning a national health program. Good citizenship demands of dentistry an enlightened social outlook.

The future is mirrored in today's activity.

The world is on the march. It is hoped that dentistry will keep in step.

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